Yamhill County Community Health Improvement Plan

2023-2027

Executive Summary

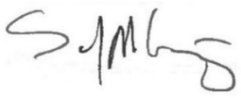
The staff, partners, and collaborators who worked on this project are largely people who live and work in this community, going to the same parks, the same doctors, and the same grocery stores. This Community Health Improvement plan reflects not only a deep commitment to the work itself, but to making the towns we care about thrive.

With robust partnership and a continued dedication to its neighbors, the Collaborative of Yamhill Community Care (YCCO), Yamhill County Public Health (YCPH), and Providence Newberg Medical Center will continuously seek the vision of a healthy, inclusive community. Through a global pandemic and crises of behavioral health and social needs, our local health partners have sought new ways to improve whole-person wellness of everyone living here.

Access to Healthcare	Access includes not only getting to an appointment but finding care that is right for a person's unique needs
Emergency Preparedness	This is an equity concern for people with accessibility or language service needs
Food and Nutrition	This focus area includes plans to get nutritious food to people's doors and make healthy choices simpler
Housing	Impacts are seen across economic categories and warrants and broad and comprehensive plan of itself
Infants and Youth	Supports for children impact a whole community's success
Mental Health & Substance Use	Programs to increase accessibility and expand the workforce
Transportation	Strategies are informed by the Yamhill County Transit Area and meant to address the transit needs specific to rural areas

In addition to looking at the community as a whole, the Collaborative used data from the Community Health Assessment to choose focus areas, to determine populations experiencing disparities in those categories or higher risk groups, or identify gaps in available data. This plan is designed with a targeted equity lens to make the most impact in improving population-wide health. This plan is ambitious and will require continued collaboration and commitment from the whole community.

Regards,



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Background and Introduction

WHO WE ARE

Providence Newberg Medical Center (PNMC), Yamhill Community Care (YCCO), and Yamhill County Public Health (YCPH), referred to as the Collaborative, are dedicated to improving health outcomes for the communities we serve. Striving to treat each person with compassion and dignity, each member of the Collaborative serves a crucial role in preventing adverse health outcomes, promoting health and healthy behaviors, and creating access to health and community services in Yamhill County.

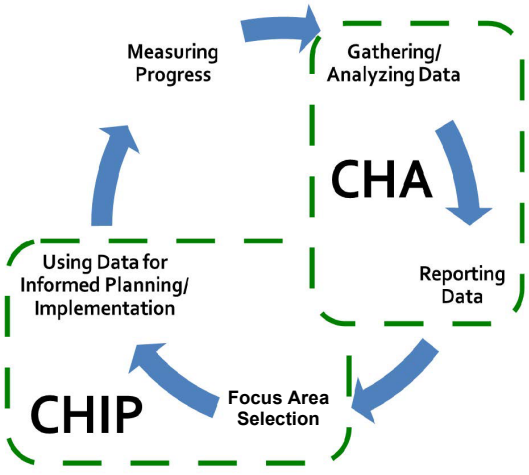
The goal of the Collaborative is to work across systems to produce a comprehensive assessment of our communities' most pressing needs and share our findings with the broader public while reducing the burden on community members and community-based organizations. The 2022 Community Health Assessment (CHA) for Yamhill County was the first iteration conducted exclusively as a collaborative and serves as the guiding document when developing improvement strategies and making targeted investments in the community. Establishing a shared understanding of community needs serves as the foundation for developing a well-informed and community focused Community Health Improvement Plan (CHIP).

COMMUNITY HEALTH IMPROVEMENT PROCESS

The CHA/CHIP Cycle

A CHA and CHIP are interrelated documents that follow a data-informed improvement cycle (Figure 1) and are typically completed every five years. The CHA/CHIP cycle begins with the identification, analysis, and reporting of qualitative and quantitative data in a CHA, a data-driven and collaborative document for the community that describes the health outcomes and the status of factors that influence health in the community. Based on data from the CHA and additional information from the community, key stakeholders, community partners, and other public health topics, Focus Areas are selected for the informed planning and implementation of the CHIP. Focus Areas in relation to this document are health topics that most greatly impact the community and where gaps and barriers in service may be present. Any Focus Areas chosen will guide the work of the

Figure 1. The CHA/CHIP Cycle



Collaborative to improve the community's health over the next several years. The CHIP is a 'living document', meaning that the goals, strategies, and progress of the work is reviewed and updated on an annual basis, or as needed, until the cycle repeats.

For the current CHA/CHIP cycle, seven Focus Areas were chosen and can be found in the 'Overview of Focus Area' section below. Further details of how these Focus Area were selected can be found in the 'Community Process' section below. These seven Focus Areas will be the backbone of our community health work and this work will be continually tracked and reviewed over several years until the next CHA/CHIP cycle. The CHA and CHIP are interrelated documents and data from the 2022 CHA will be listed throughout this document.

Mobilizing for Action Through Planning and Partnerships

In order to guide the process of developing the CHIP, the Collaborative chose the Mobilizing for Action through Planning and Partnerships (MAPP) process as the planning framework. The MAPP framework, developed by the National Association of County and City Health Officials (NACCHO), was chosen to capture an in-depth picture of community health status through quantitative and qualitative data collection methods.[1] There are six phases of MAPP, and the CHIP process largely involves Phases 4-6:

- Phase 1: Organize for Success and Partnership Development
    - Identify the Core Team that is responsible for most of the work.
    - Recruit and convene a Steering Committee from representatives of the community and the local public health system.
    - Develop a work plan and conduct readiness assessments.
- Phase 2: Visioning
    - Develop vision and values statements for the CHA/CHIP process.
- Phase 3: The Four Assessments
    - Collect and analyze data through four different assessments:
        - Community Themes and Strengths Assessment
        - Local Public Health System Assessment
        - Community Health Status Assessment

Figure 2. MAPP Framework

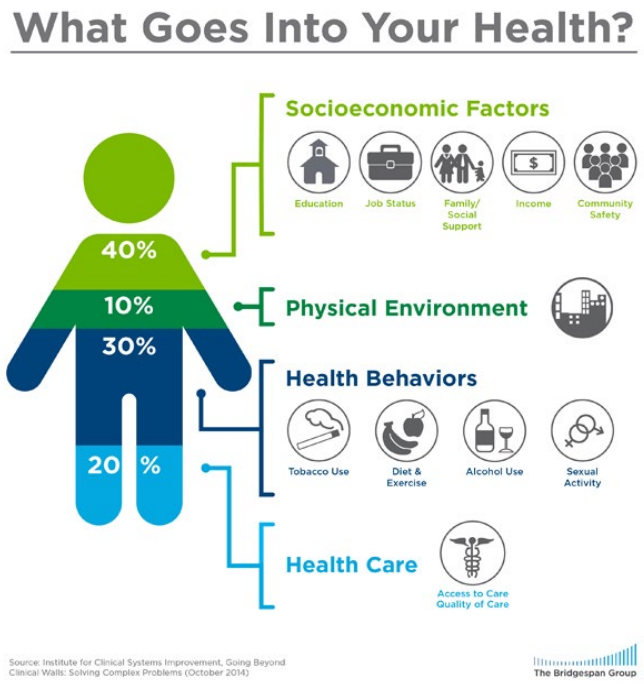
Source: National Association of County and City Health Officials (NACCHO)

[1] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

        - Forces of Change Assessment
- Phase 4: Identify Strategic Issues
    - Analyze the results of the four assessments in Phase 3 to identify the most important issues facing the community and how those issues affect the achievement of the shared vision.
- Phase 5: Formulate Goals and Strategies
    - Use the Strategic Issues identified in Phase 4 to formulate goals and broad strategies that address those issues.
- Phase 6: Action Cycle
    - Develop an Action Plan(s) with realistic and measurable objectives related to each Strategic Issue and track the progress.
    - Evaluate and continuously improve the goals and strategies in the Action Plan(s), and the local public health system as a whole.

FACTORS THAT INFLUENCE HEALTH

Figure 3. Factors Contributing to Overall Health and Well-Being



Source: Institute for Clinical System Improvement

To improve the health of our communities, we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.[2] Social determinants of health (SDOH) are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, well-being, and quality-of-life outcomes and risks.[3] SDOH also contribute to wide health disparities and inequities. Simply promoting healthy choices won't eliminate health disparities and, instead, community organizations, healthcare systems, public health agencies, and policy makers should work together to develop policies, programs, and systems rooted in specific community needs and based on health equity frameworks.

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

[3] https://health.gov/healthypeople/priority-areas/social-determinants-health

HEALTH EQUITY AND DISPARITIES

Someone's health is impacted by social, economic, and environmental factors, as well as access to health care, and each of these factors is also influenced by a person's identity. The CHA is an important tool we used to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets. To better understand the needs of the community throughout the CHA process, the Collaborative applied an equity lens to consider how the health and experience of each individual is unique based on where they live, what identities they hold, and what resources they have available. To do this, the Collaborative looked at how differences in things like race, gender, language, and zip code showed differences in health factors.

When creating the CHIP, this data from the CHA helped the Collaborative develop strategies based not just on overall or average need but also targeted towards those who may be most affected. For instance, emergency preparedness appeared as a priority in some community listening sessions, but because people with disabilities are at higher risk in an emergency, this population, among others, are included as a priority.[4] While food resources, including food pantries and free community meals, are readily available in the larger communities of McMinnville and Newberg, people in rural communities, especially those without access to reliable transportation, experience a greater disparity. Therefore, strategies in this Focus Area address transportation limitations and explore options like mobile pantries and delivery services. In some areas, demographic-specific data was limited or unavailable, warranting strategies relating to gathering baselines or identifying target populations with further research. The success of this plan is dependent on meeting needs of *all* community members according to their individual backgrounds and identities, and letting local voice lead in defining those needs.

COMMUNITY PROCESS

In an effort to be community-led and to ensure that the input from those most affected by local programs and policies is woven throughout the CHIP, the Collaborative hosted four Community Health Improvement Plan Workshops. There were three in-person sessions, located in Newberg, McMinnville, and Sheridan, and one virtual session, hosted over Zoom, and the sessions were held between February and March 2023. These sessions were an opportunity for community members to review the information collected in the CHA and to provide their feedback and personal experiences related to the strengths and needs in Yamhill County. Participants at the sessions voted on their top five Focus Areas in which they would like to see addressed during the CHIP process. In addition, participants discussed specific strategies or objectives that would address their selected Focus Areas. There was a total of approximately 70

[4] Kett M, Twigg J. Disability and disasters: towards an inclusive approach. 2007. https://www.sistemaprotezionecivile.it/allegati/1476_Disability_and_disasters.pdf

participants across all four sessions representing both community members and local community-based organizations.

At the end of all four sessions, the top ranked Focus Areas and strategies and objectives suggested by the community were reviewed by the Collaborative. While we made it a priority to select Focus Areas and strategies that were community-identified, we also had to consider the feasibility and practicality of some of the suggestions and what could realistically be completed in five years. In addition, we considered what current work is already happening in Yamhill County, any financial, staff, or resource constraints, and any additional organizational roles and scopes. At the end of the reviewal process, we selected seven Focus Areas. An overview of all seven Focus Areas can be found in the 'Overview of Focus Area' section below.

In order to continue gathering community input throughout the CHIP process and to not duplicate work already happening in the community, advisory groups were identified for each of the seven Focus Areas. These groups, which consist of community members and partners whose work relates to one of the Focus Areas, have reviewed and provided feedback on the goals and strategies outlined in this document. In addition, the advisory groups will continue to be our main points of contact for progress updates on the goals and strategies and will continue providing feedback throughout the entire CHA/CHIP cycle. Some Focus Areas have more than one advisory group and the CHIP document as a whole was vetted through several community groups to further gain feedback and community voice. We are thankful for the partnerships we have gained and strengthened throughout the CHA/CHIP process.

GAPS AND LIMITATIONS

While the CHA is used to inform the CHIP, the qualitative data presented should not be interpreted as representative of Yamhill County as a whole, as it is based only on participants' perceptions, experience, and knowledge. The data are limited in several instances throughout the document, including limited stratification of quantitative data by certain demographics, such as race/ethnicity, income, or age, as well as suppressed data, due to small numbers. Efforts were made throughout this process to engage and limit barriers to participation for priority populations during survey distribution and listening sessions. However, not every group was reached or able to participate.

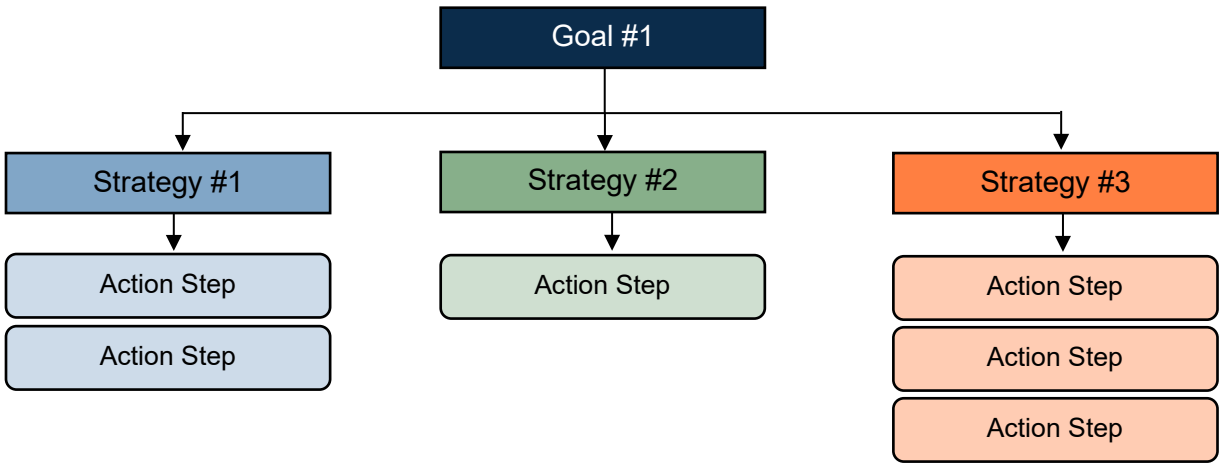
While developing the CHIP, the Collaborative revisited the community during every stage of the process, from validating the CHA data to prioritizing and finalizing Focus Areas. However, community members often self-select participation, and representative community feedback cannot be guaranteed. Additionally, in developing the strategies, the Collaborative identified and worked closely with community advisory groups of subject matter experts, but limitations on meeting frequency created difficulty in coordinating robust feedback. Finally, this document will be a living document, with a partner workplan, and strategies and action steps under each focus area may change according to available resource, community need, and local support.

PLANS FOR MEASURING PROGRESS

In order to measure the progress of our work over the next five years, we have developed a strategic planning framework involving goals, strategies, and action steps. The framework is set up in a cascading tree-like shape, as seen in Figure 4 below.

Each of the seven Focus Areas has at least one goal. The identified goal(s) are overarching and broad, and achievement of these goals help to address the specific Focus Area. Under each goal, there are subsequent strategies and action steps. Action steps are small, specific, and typically require a single action, and completion of these action steps help us to meet our strategies. Strategies are slightly more specific than goals and typically focus on a specific population or a segment within the Focus Area but are still broad enough to encompass several action steps. This framework allows us to see the overall progress, as well as visualize how completion of each action step help us to achieve our goals.

Figure 4. CHIP Strategic Planning Framework



The goals and strategies for each Focus Area are outlined in this document. However, because there are several (sometimes dozens of) action steps for each strategy, and they may change frequently based on a variety of factors, action steps are not included in this document and are instead detailed in a separate workplan. This workplan is shared with all members of the Collaborative and relevant advisory groups and is updated on a monthly basis, or as needed. In addition, the workplan will provide more detail on which organizations will lead, or completely carry out, the work for specific action steps, if necessary, and which ones will be shared across the Collaborative and/or advisory groups.

While there are a number of agreed-upon strategies identified for each Focus Area, this is not an exclusive list of all the work happening to improve the health of our community. We aim to support as much of the work done by our partners and other community-based organizations as we can.

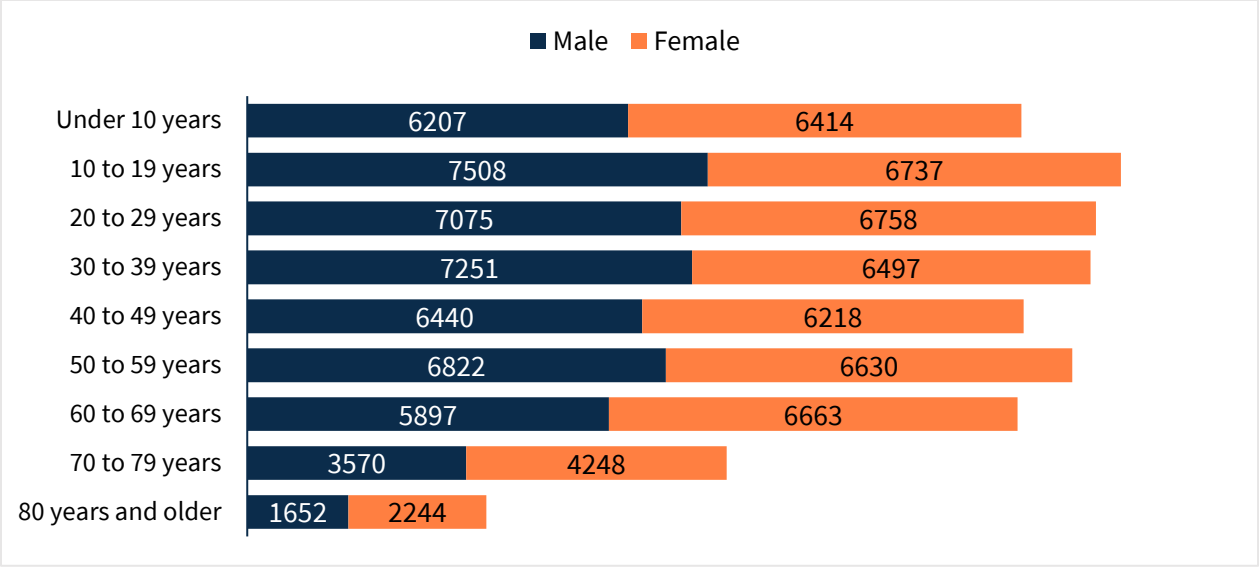
OUR COMMUNITY

Figure 5. Location of Yamhill County

Yamhill County is home to approximately 108,000 people.[5] 34,000 people live in the city of McMinnville, the county seat and largest city in Yamhill County. Approximately 23% of the county population live in unincorporated rural areas. Yamhill County is centrally located within the Willamette Valley, with close proximity to the Oregon Coast, the metropolitan areas of Portland and Salem, and the Oregon Cascade Mountains. The Confederated Tribes of Grand Ronde reside in the southwestern portion of the county.

According to 2019 U.S. Census Bureau data, the percentage of males and females in Yamhill County are approximately equal in most age groups, and the age distribution is typical for an overall growing population. The median age is 38 years old, compared to the median age in Oregon at 39 years old. White, not Hispanic or Latino individuals make up 87.5% of the total population. The largest non-white population in Yamhill County are Hispanic or Latino, making up almost 16% of the total population, and 12.6% report speaking a language other than English

Figure 6. Population by Age and Sex, Yamhill County, 2015-2019

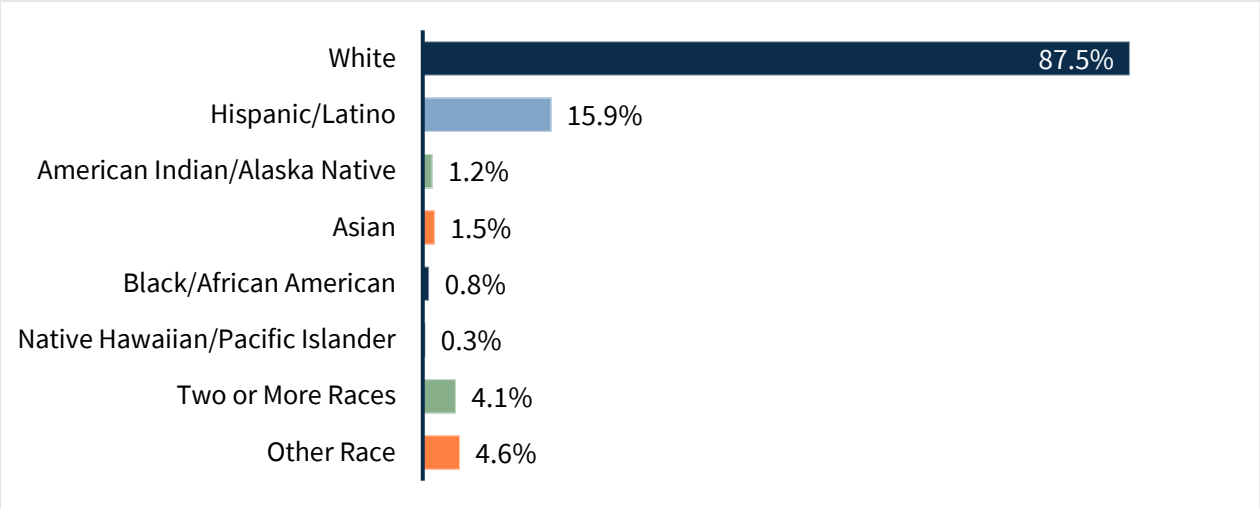


Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2015-2019

[5] https://www.pdx.edu/population-research/population-estimate-reports

in the home.[6] The majority of non-English language speakers speak Spanish, with Vietnamese, Russian, Ukrainian, and Chinese in the top of the remaining 5%.[7]

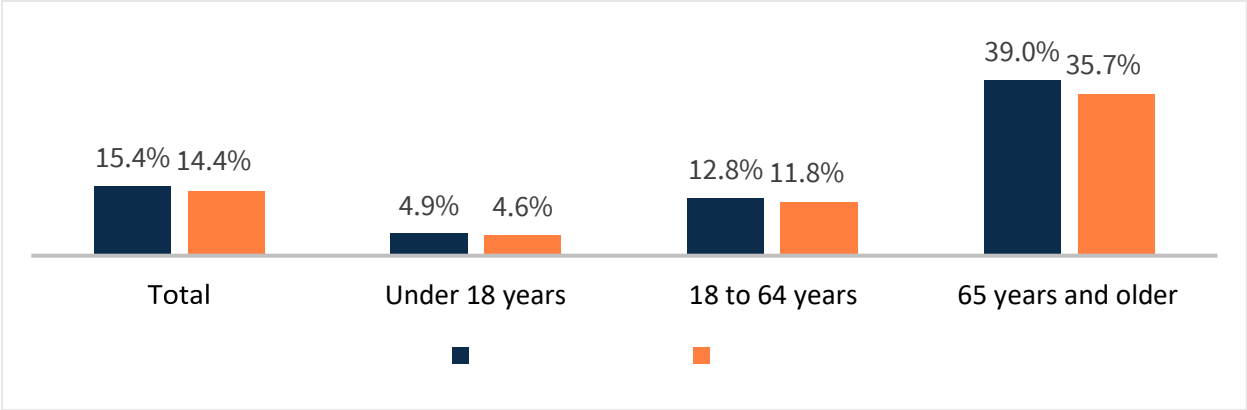
Figure 7. Percent of Population by Race and Ethnicity, Yamhill County, 2015-2019



Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2015-2019

Approximately 15% of noninstitutionalized Yamhill County residents have a disability, slightly higher than the 14% of total noninstitutionalized Oregon residents.[8] A disability in this context is defined as someone having a hearing, vision, cognitive, ambulatory, self-care, and/or independent living difficulty.

Figure 8. Percent of Population with a Disability, Yamhill County and Oregon, 2015-2019



Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2015-2019

[6] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, data.census.gov

[7] Yamhill Community Care membership data. Community Integration Manager. 3.23.23

[8] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, data.census.gov

Overview of Focus Areas

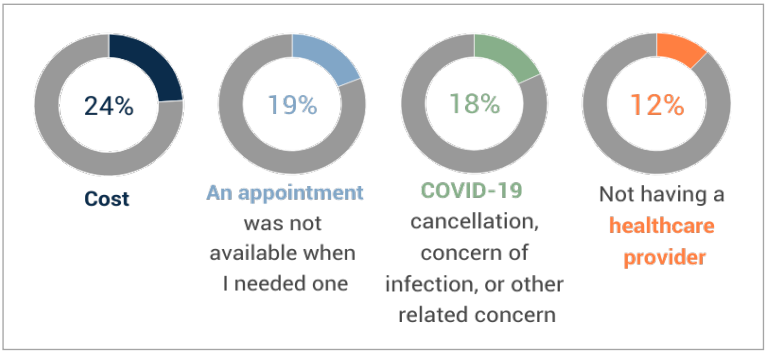
FOCUS AREA: ACCESS TO HEALTHCARE

Overview

Access to healthcare in this CHIP can mean multiple things. Access is the ability to *get* healthcare, which can be making appointments, finding transportation, or having a provider available. But access is also the availability of services that are affordable, meet individuals' cultural needs, specific health conditions, and meet requirements for language accessibility.

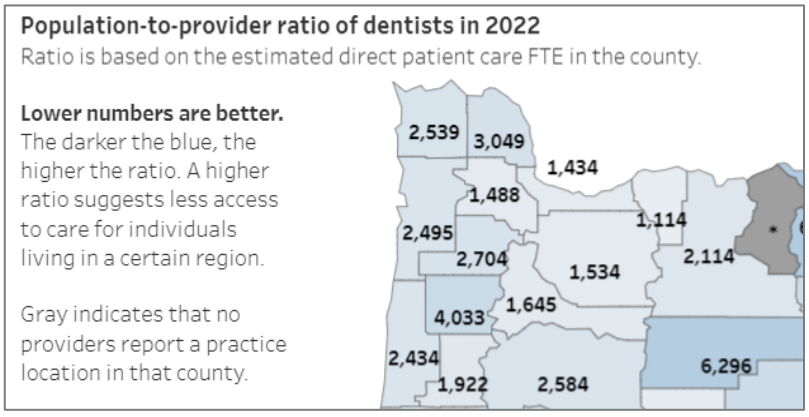
In the 2022 CHA Community Survey, 24% of respondents reported not getting all the care they needed, and 12% had a delay in care. Stakeholders and listening session participants spoke about long wait times and a need for primary care, specialty, and bilingual/bicultural providers. COVID-19 had a marked impact not only on overall health, but also in access to care and in patients' willingness to access care. Provider shortages have been more prevalent since COVID-19.

Figure 9. Percent of Survey Respondents Answering, "The last time you or anyone in your family put off or went without healthcare, what were the reasons?"



Source: Yamhill Community Survey, 2022

Figure 10. Population-Provider Ratio of Dentists in Yamhill County, 2022



Source: Oregon Health Authority, Workforce Supply by County, 2022

For every 405 people in Yamhill County, there is the equivalent of one full time provider who can be classified as a primary care provider (i.e., physician, physician assistant, nurse practitioner, or naturopathic physician), which is slightly higher than the state average. There is one full-time dentist per 2,704 people, as seen in Figure 10. Most strikingly, there is one full-time behavioral health provider (psychologist, therapist, counselor, or licensed clinical social worker) for every 9,538 individuals.[9] These numbers reinforce the 2022 CHA Community Survey and listening session data that report especially

[9] https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonslicensedhealthcareworkforce/Supplybycounty?%3Aorigin=card_share_link&%3Aembed=y&%3AisGuestRedirectFromVizportal=y#1

FOCUS AREA: ACCESS TO HEALTHCARE

long wait times for mental health or substance use supports and oral health care. For providers within the YCCO network, only 5.7% report speaking a language other than English.[10] While there are robust language services available, the provider population exhibits less diversity than the patient population they serve.

HEALTH INDICATOR METRICS

Some of the indicators listed below are data from the CHA that illustrate part of the reason that access to healthcare was chosen as a Focus Area. Additional indicators were selected based on the goals and strategies we developed. Identifying indicators at the beginning of the CHIP cycle helps us to measure and track our progress over time in order to meet our goals.

Indicator	Current State	Source (Year)
Ratio of population to primary care providers	1680:1	County Health Rankings (2020)
YCCO member emergency department utilization, per 1,000 people	484.7	YCCO (2022)
YCCO member, primary care utilization	53%	YCCO (2022)
YCCO member, dental utilization	36.9%	YCCO (2022)
YCCO member, physical health telehealth visits, per 1,000 members	86.6	YCCO (2022)
YCCO member, dental telehealth visits, per 1,000 members	207.9	YCCO (2022)
YCCO member, behavioral telehealth visits, per 1,000 members	301.5	YCCO (2022)

[10] Yamhill Community Care. Delivery Service Network Report 5.30.23.

FOCUS AREA: ACCESS TO HEALTHCARE

GOALS AND STRATEGIES

The following goals and strategies were developed by the Collaborative and aim to impact the indicators listed above.

Goal 1: Increase access to specialty care and providers.
Strategy 1: Increase availability of telehealth services.
Strategy 2: Increase availability of mobile health services.
Strategy 3: Ensure effective utilization of specialty care.

Goal 2: Increase access to complementary and alternative medicine (CAM)* providers.
Strategy 1: Support CAM providers that accept Medicaid to effectively bill for services.
Strategy 2: Support the integration of CAM providers into care teams/care management for chronic conditions.

*CAM includes but is not limited to acupuncture, chiropractic, massage therapy, and other alternative modalities or medicine.

Goal 3: Increase recruitment, training, and retention of medical providers.
Strategy 1: Partner with local colleges and universities for workforce development.
Strategy 2: Explore partnerships with hospitals and clinics.

Goal 4: Increase access to primary care providers.
Strategy 1: Provide patient language access education to primary care offices.
Strategy 2: Increase availability of telehealth services.

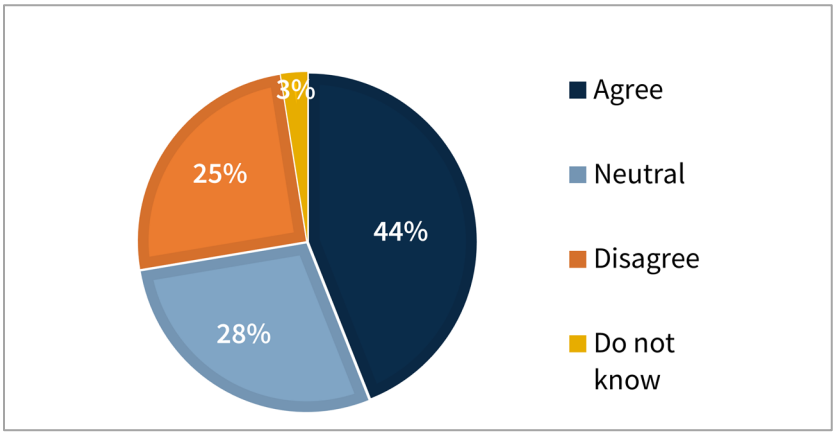
FOCUS AREA: EMERGENCY PREPAREDNESS

Overview

Emergency situations due to natural hazards (i.e., earthquakes, hurricanes, floods, droughts, wildfires, etc.), outbreaks, and human-made disasters (i.e., war, chemical spills, bioterrorism, etc.) can pose significant challenges to communities and the public's physical and mental health. Natural disasters are becoming increasingly more common and frequent across the United States and the world, in part due to climate change. In Yamhill County, the hazards that pose the greatest threat are flooding, winter storms, and earthquakes in the Cascadia subduction zone (reaches from Seattle, WA down to Eugene, OR).[11]

Emergency situations can happen at any time, and it's important to be prepared in order to save lives and reduce suffering. In addition to reducing deaths, being prepared can also reduce fear, anxiety, and increase resiliency within a community. The impact of disasters can be greatly reduced when community members know what to do during an emergency, where to go in case of evacuations, and how to care for their basic medical needs during an emergency.

Figure 11. Percent of Survey Respondents Ranking, "My family and I are prepared for emergencies (earthquakes, wildfires, extreme weather, and other natural disasters)."



Source: Yamhill Community Survey, 2022

In the 2022 CHA Community Survey, when survey respondents were asked about their emergency preparedness regarding earthquakes, wildfires, extreme weather, and other natural disasters, 44% reported that they are prepared for emergencies.

HEALTH INDICATOR METRICS

Some of the indicators listed below are data from the CHA that illustrate part of the reason that emergency preparedness was chosen as a Focus Area. Additional indicators were selected based on the goals and strategies we developed. Identifying indicators at the beginning of the CHIP cycle helps us to measure and track our progress over time in order to meet our goals.

[11] https://www.mcminnvilleoregon.gov/sites/default/files/fileattachments/fire/page/853/yamhill_county_mnhmp_-_2020_update.pdf

FOCUS AREA: EMERGENCY PREPAREDNESS

Indicator	Current State	Source (Year)
Number of active MRC volunteers	178	YCPH (2023)
Number of active CERT volunteers	46	YCEM (2023)
County-wide Everbridge registrants	20,729	YCEM (2023)
Emergency department visits for heat-related illness, any Oregon hospital	54	ESSENCE (2022)
Number of environmental health materials/tools/supplies requested and provided to community	58	YCCO (2023)

GOALS AND STRATEGIES

The following goals and strategies were developed by the Collaborative and aim to impact the indicators listed above.

Goal 1: Prevent adverse health effects due to extreme weather events, wildfires, and environmental hazards.
Strategy 1: Increase shelter availability during extreme weather.
Strategy 2: Increase awareness about extreme weather and wildfire resources.
Strategy 3: Partner with organizations to support worker safety.

Goal 2: Increase community readiness for natural disasters and extreme weather.
Strategy 1: Offer community wide preparedness trainings, in multiple languages, that are culturally responsive and encompass all abilities.
Strategy 2: Increase enrollment in Medical Reserve Corps (MRC)* and Community Emergency Response Team (CERT)**.

*MRC is a community-based volunteer group of licensed healthcare workers that are called upon to assist and respond to public health disasters and emergencies.

**CERT volunteers receive training in basic disaster response skills and assist professional responders during disasters and emergencies.

FOCUS AREA: EMERGENCY PREPAREDNESS

Goal 3: Improve communication during emergencies for different populations.
Strategy 1: Expand awareness and use of Everbridge*.
Strategy 2: Increase multilingual and multimodal communication documents for emergencies and evacuations.

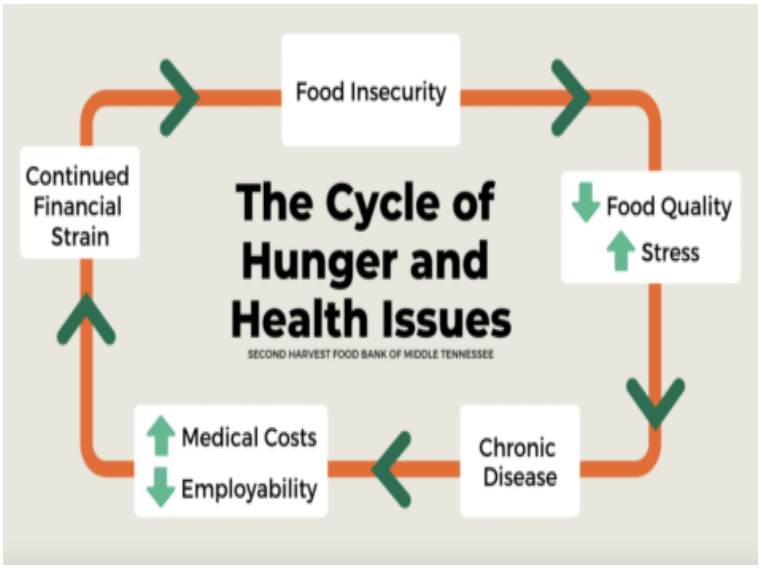
*Everbridge is Oregon's Emergency Alert Program that enables users to quickly receive information during disasters and emergencies by phone, text, or email.

FOCUS AREA: FOOD AND NUTRITION

Overview

Nutrition is a foundational component of health and well-being. Reliable access to healthy food is associated with lower rates of chronic disease and is correlated with a reduction in severity of chronic disease symptoms. Addressing barriers to consistent access to healthy, culturally appropriate food among populations at high risk for chronic food insecurity can improve social and emotional health and reduce disease burden, thereby reducing healthcare costs.

Figure 12. The Cycle of Hunger and Health Issues.



Source: Second Harvest Food Bank, accessed 2023

Culturally appropriate food is a key factor in social and emotional health. Community feedback reported plentiful food resources, but limitations on access to those resources, especially in more rural areas, as well as shortages of culturally relevant foods.

Food insecurity is a strong predictor of increased risk of developing chronic disease and premature death. Populations experiencing food insecurity include those with low income and those living in food deserts. Generally, a 'food desert' refers to geographic areas where access to affordable and nutritious food is limited. Factors such as income, access to transportation, and the number of food retailers that provide fresh produce and other healthy foods at affordable prices influence whether an area can be considered a 'food desert'.[12]

As of December 2022, large portions of Yamhill County are categorized as 'low access to nutritious foods at 1 and 10 miles' and 'low income'. 'Low access to nutritious foods' is defined as 'tracts in which at least 500 people or 33% of the population lives farther than 1 mile (urban) or 10 miles (rural) from the nearest supermarket' and largely includes the northeast part of Yamhill County. 'Low income' is defined as 'tracts with a poverty rate of 20% or higher, or tracts with a median family income less than 80% of the state or metropolitan area' and largely includes the West Valley.[13]

The Food Environment Index ranges from a scale of 0 (worst) to 10 (best) and equally weighs two indicators of the food environment:

[12] https://www.ers.usda.gov/webdocs/publications/45014/30940_err140.pdf

[13] https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/

FOCUS AREA: FOOD AND NUTRITION

1) Limited access to healthy foods estimates the percentage of the population that is low income and does not live close to a grocery store.
2) Food insecurity estimates the percentage of the populations that did not have access to a reliable source of food during the past year.

The Food Environment Index in Yamhill County is 8.5, compared to overall in Oregon at 8.1. Neighboring counties Polk and Washington reported an 8.0 index and 9.0 index, respectively. Compared to the rest of Oregon, Yamhill County is performing similarly or better in many food-related measures.[14] In Yamhill County in 2019, 10,670 individuals were considered food insecure, or 10% of the county, compared to the Oregon average of 12%.[15] Three percent of Yamhill County residents had limited access to healthy foods, compared to an average of 5% in Oregon; although up to 51% of residents in some Oregon counties have limited access to healthy foods.[16]

HEALTH INDICATOR METRICS

Some of the indicators listed below are data from the CHA that illustrate part of the reason that food and nutrition was chosen as a Focus Area. Additional indicators were selected based on the goals and strategies we developed. Identifying indicators at the beginning of the CHIP cycle helps us to measure and track our progress over time in order to meet our goals.

Indicator	Current State	Source (Year)
Percent of population that is food insecure	10%	County Health Rankings (2020)
Percent of population with limited access to healthy foods	3%	County Health Rankings (2019)
Number of individuals served through mobile food pantries	12,876	YCAP (2022)

[14] https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/133/description

[15] https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/139/datasource?sort=desc-0

[16] https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/83/data?sort=desc-0

FOCUS AREA: FOOD AND NUTRITION

GOALS AND STRATEGIES

The following goals and strategies were developed by the Collaborative and aim to impact the indicators listed above.

Goal 1: Align transportation and food infrastructure to ensure broader access to nutritious foods.
Strategy 1: Increase mobile food pantry scope, geographic range, and populations served.
Strategy 2: Explore and develop food delivery services for populations at-risk of food insecurity that are culturally appropriate.
Strategy 3: Explore and develop food delivery services for populations with specific dietary or medically specific needs.

Goal 2: Ensure accurate, reliable information on healthy eating and that community members have trusted sources to obtain information they need.
Strategy 1: Offer culturally appropriate nutrition education and cooking classes.
Strategy 2: Partner with existing community-based organizations to build upon existing food related resources.

Goal 3: Increase the accessibility and affordability of nutritious perishable and preserved food options.
Strategy 1: Support rural retailers to implement federally funded nutrition programs.
Strategy 2: Develop or expand VeggieRx or similar model locally.

FOCUS AREA: HOUSING

Overview

Housing can include many categories along a spectrum, from houselessness to unstable housing (i.e., couch surfing), to precarious housing (i.e., at risk of eviction). It may also include being housed in unsafe conditions or without the resources needed to stay healthy, such as accommodations for a disability or electricity to support medical equipment. People need safe and stable housing to reach their full health potential. In addition, housing may be defined as having four dimensions: housing, or the place that offers shelter; dwelling, or structure and condition of the shelter; community, or neighborhood; and dwelling environment, or surrounding areas like streets and parks.[17] Overall, evidence shows that affordable, energy efficient, and well-ventilated housing with temperature controls improves wellbeing.[18]

Feedback from the community emphasized that the high cost of housing is a burden for many families, along with little housing stock and often poor-quality rentals. The cost of housing has been increasing, but incomes are not, contributing to over-crowding and families making spending tradeoffs. In the most recent point in time homeless count in January 2020, 1,428 people were counted as living in shelters, in unsheltered locations, or couch surfing.[19] In a small sample (N=55) of people experiencing homelessness and engaged with temporary shelter through Yamhill Community Action Partnership's Project Turnkey, 56% of those individuals had current or past involvement with the justice system.[20] Most Yamhill County residents are homeowners with or without a mortgage (70%), while 30% of residents are renters.[21] Only 10.7% of homeowners are Hispanic/Latino, even though they make up 15.9% of the total population.[22]

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[17] Bonnefoy, X. (2007). Inadequate housing and health: an overview. International journal of environment and pollution, 30(3-4), 411-429. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=a8b9a85c4bbc2b05750eaa92f3b6401fe3c2cc7a

[18] Janet Ige and others, The relationship between buildings and health: a systematic review, *Journal of Public Health*, Volume 41, Issue 2, June 2019, Pages e121–e132, https://doi.org/10.1093/pubmed/fdy138

[19] https://www.flipsnack.com/ycap2020pitcount/final-2020-pit-report.html

[20] Unpublished Project Turnkey report 3.2022

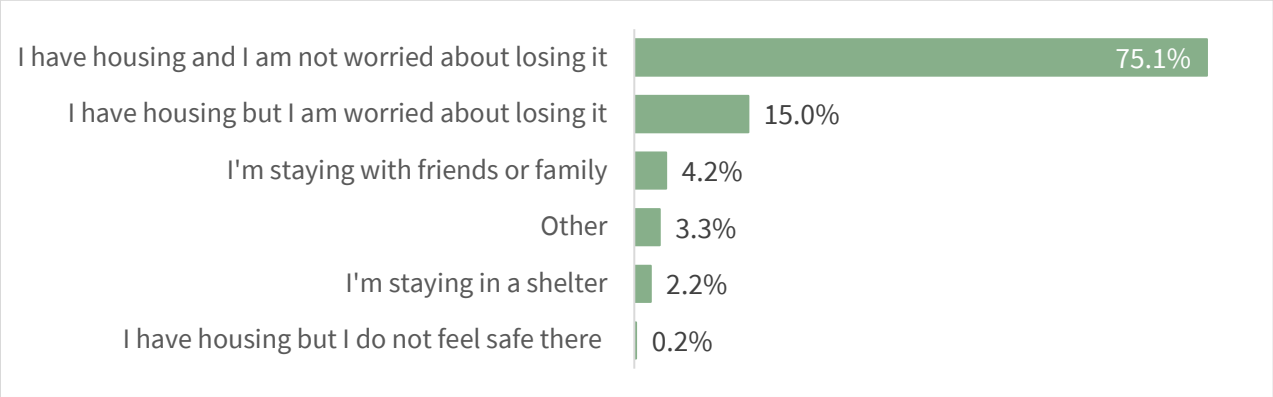
[21] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, data.census.gov

[22] https://data.census.gov/cedsci/table?q=housing%20yamhill%20county&tid=ACSST1Y2021.S2502

FOCUS AREA: HOUSING

Only 75% of 2022 CHA Community Survey respondents were in stable housing and weren't worried about losing it. In addition, 53% of the survey respondents feel that there is not enough housing for everyone. When selecting CHIP strategies, the Collaborative considered not only work to address homelessness, but also work to keep individuals in housing, especially those with higher health risks or housing barriers. Additional barriers or risks may be present for individuals with behavioral health challenges, people with disabilities, immigrants and undocumented individuals, and those with histories of incarceration, and these populations were prioritized in housing strategies.

Figure 13. Percent of Survey Respondents Answering, "Which of the following best describes your housing situation today?"



Source: Yamhill Community Survey, 2022

HEALTH INDICATOR METRICS

Some of the indicators listed below are data from the CHA that illustrate part of the reason that housing was chosen as a Focus Area. Additional indicators were selected based on the goals and strategies we developed. Identifying indicators at the beginning of the CHIP cycle helps us to measure and track our progress over time in order to meet our goals.

Indicator	Current State	Source (Year)
Annual point-in-time homeless count	1,458	YCAP (2020)
Available transitional housing units in the county	To be determined	YCHHS
Number of voucher-eligible individuals who were successfully housed	50%	HAYC (2023)
Number of units of low-income housing	To be determined	YCHHS

FOCUS AREA: HOUSING

GOALS AND STRATEGIES

The following goals and strategies were developed by the Collaborative and aim to impact the indicators listed above.

Goal 1: Align and coordinate housing projects and initiatives.
Strategy 1: Assess and track current housing projects.
Strategy 2: Support clear communication between housing-involved agencies.

Goal 2: Prioritize housing supports for identified high-need populations.
Strategy 1: Identify individuals within high-need populations.
Strategy 2: Work with partners to provide population specific supports and resources.

Goal 3: Increase temporary housing capacity.
Strategy 1: Increase shelter capacity.
Strategy 2: Increase transitional housing.

FOCUS AREA: INFANTS AND YOUTH

Overview

The wellbeing of infants and youth is a key predictor of the long-term health of a community. While many programs are available to support youth and families, connection to or qualification for these programs may be lacking, and coordinated services are needed to help address these gaps.

Community feedback from the 2022 CHA indicated concern for children with disabilities or medical risk factors, resource/foster children, and LGBTQ2SIA+ youth within the community. Material hardships, such as housing among people in poverty, have been associated with an increased likelihood of a Child Protective Services (CPS) investigation, indicating that inadequately housed families are disproportionately more likely to have CPS involvement.[23] In addition, there is evidence of disproportionate repeat CPS involvement for families where the caregiver has a hard time paying bills, has health problems, or has a child with developmental disabilities.[24]

Yamhill County is considered a childcare desert, with limited quality childcare options. Only 18% of children 0-5 had access to a childcare slot as in 2020.[25] Quality childcare is linked to better academic and success measures for children and offers a valuable resource for working caregivers.[26] According to a 2022 childcare and preschool community assessment by the Yamhill Early Learning Hub, while there were 608 available preschool slots, and some level of overrepresentation of Hispanic/Latino children (around 30% of Hispanic/Latino children enrolled in the program, compared to 16% of the total Hispanic/Latino population in the county), many spots went unfilled because children didn't qualify, even though the need remained high. In addition, the FamilyCore home visiting referral network in 2022 offered services for up to 864 children and had the ability to accept a high number of new referrals, but services were largely underutilized. In developing the CHIP strategies, the Collaborative aligned closely with the Yamhill Early Learning Hub's Strategic Plan and the local Family Well-Being Council's Workplan. The CHIP strategies listed below aim to address both the gap in connecting families to existing services and the need for expansion of certain services, especially for specific populations.

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[23] Yang MY. The effect of material hardship on child protective service involvement. Child Abuse Negl. 2015 Mar;41:113-25. doi: 10.1016/j.chiabu.2014.05.009. Epub 2014 Jun 5. PMID: 24908518. https://pubmed.ncbi.nlm.nih.gov/24908518/

[24] Kahn, J. M., & Schwalbe, C. (2010). The timing to and risk factors associated with child welfare system recidivism at two decision-making points. Children and Youth Services Review, 32(7), 1035-1044.

[25] https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/research/oregons-child-care-deserts-2020.pdf

[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7962710/

FOCUS AREA: INFANTS AND YOUTH

HEALTH INDICATOR METRICS

Some of the indicators listed below are data from the CHA that illustrate part of the reason that infants and youth was chosen as a Focus Area. Additional indicators were selected based on the goals and strategies we developed. Identifying indicators at the beginning of the CHIP cycle helps us to measure and track our progress over time in order to meet our goals.

Indicator	Current State	Source (Year)
Child maltreatment rate per 1,000	7.4	Oregon DHS (2021)
Percent of students that attend >90% of enrolled days, all districts in Yamhill County	66%	ODE (2022)
Children in resource/foster care per 1,000	3.1	Oregon DHS (2021)
Certified resource/foster homes	64	Oregon DHS (2021)
Referrals to FamilyCore home visiting	431	YCCO, YCHHS (2022)

GOALS AND STRATEGIES

The following goals and strategies were developed by the Collaborative and aim to impact the indicators listed above.

Goal 1: Increase utilization of available pre-K services.
Strategy 1: Expand awareness of pre-K educational opportunities.
Strategy 2: Expand connections between pre-K programs and healthcare services.

FOCUS AREA: INFANTS AND YOUTH

Goal 2: Increase resiliency in children and families.
Strategy 1: Connect to high-risk populations to increase awareness of available services.
Strategy 2: Increase access to behavioral health supports for children and families.
Strategy 3: Increase capacity and stability of resource/foster care system.
Strategy 4: Reduce child abuse.

Goal 3: Increase the stability and diversity of the childcare and education workforce.
Strategy 1: Promote workforce skill development programs for high school students.

Goal 4: Reduce preventable injuries in youth.
Strategy 1: Expand community prevention and education programs.
Strategy 2: Develop messaging campaign for youth safety.

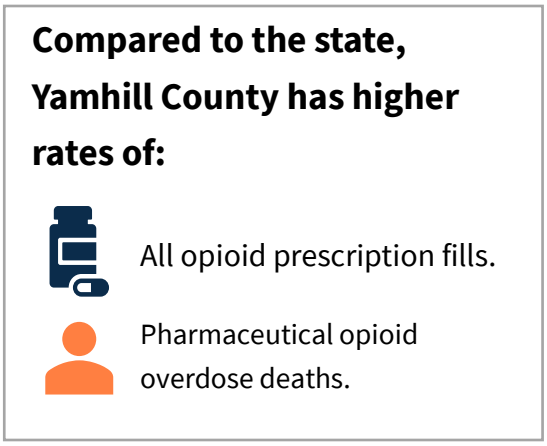
Goal 5: Improve the health and wellness of students in schools.
Strategy 1: Increase access to on-site school health services and health centers.
Strategy 2: Increase school-based wellness and prevention education.

FOCUS AREA: MENTAL HEALTH AND SUBSTANCE USE

Overview

Addressing mental health and substance use/misuse in the community is a major need that should be addressed collectively and collaboratively with the community. Mental health and substance use disorders, collectively referred to as behavioral health, effect one in five adults in the United States.[27] Behavioral health encompasses not only mental health and emotions, but also substances and their abuse, health behaviors, and other external forces that contribute to the overall mental wellness of a person.

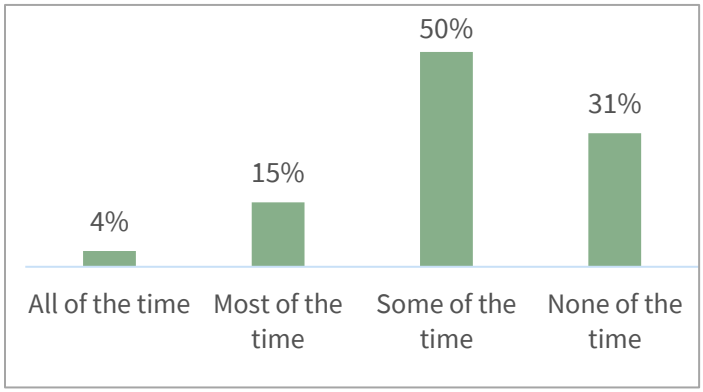
Figure 14. Yamhill County Opioid Use



Source: Yamhill County Substance Use Disorder Services Needs Assessment & Priority Setting, 2022

Substances, such as alcohol, tobacco, and other drugs (illegal or not), have a high potential to be used in an excessive and harmful way. Substance abuse and misuse describes the use of substances in a way that is not intended or recommended, or overusing the substance. Substance abuse and misuse can lead to significant problems or distress, affecting relationships, employment, and health. Oregonians experience one of the highest rates of substance use and substance use disorders in the nation and on average, four Oregonians die every day from alcohol and other drug use, and many others experience significant health and social problems.[28]

Figure 15. Percent of Survey Respondents Answering, "In the last year, how often did you feel socially isolated or experience loneliness?"



Source: Yamhill Community Survey, 2022

Depression is a disorder of the brain that effects how a person thinks, feels, and behaves on a daily basis. Depression symptoms are typically persistent, disrupt daily activities, and can be serious enough to lead to suicide and self-harm.[29] Suicide is a leading cause of death in the United States, responsible for nearly 46,000 deaths in 2020.[30] In addition to 50% of the 2022 CHA Community Survey respondents feeling social isolated or experiencing

[27] https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health

[28] https://www.oregon.gov/adpc/SiteAssets/Pages/index/Statewide%20Strategic%20Plan%20Final%20(1).pdf

[29] https://www.nimh.nih.gov/health/publications/depression

[30] https://www.cdc.gov/suicide/

loneliness 'some of the time' during the past year, 44% of survey respondents experienced little interest or pleasure in doing things during the last two weeks.

Mental health and substance abuse care not only requires financial coverage, but also access to providers of care. Nearly 30% of the U.S. population lives in a county designated as a Mental Health Professional Shortage Area.[31] The ratio of the population to mental health providers is a useful measure to see the number of individuals served by one mental health provider in each county and statewide, if the population was equally distributed across providers.[32] In Yamhill County, there are approximately 210 people per 1 mental health provider, slightly higher than 170 people per 1 mental health provider statewide.[31] Mental health providers in this measure are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.

HEALTH INDICATOR METRICS

Some of the indicators listed below are data from the CHA that illustrate part of the reason that mental health and substance use was chosen as a Focus Area. Additional indicators were selected based on the goals and strategies we developed. Identifying indicators at the beginning of the CHIP cycle helps us to measure and track our progress over time in order to meet our goals.

[31] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport

[32] https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/62/description

FOCUS AREA: MENTAL HEALTH AND SUBSTANCE USE

Indicator	Current State	Source (Year)
Traditional Health Workers (THWs) focused on mental health	101	YCCO (2022)
Ratio of population to mental health providers	210:1	County Health Rankings (2022)
Suicide death rate per 100,000	17.75	OPHAT (2020)
Opioid overdose death rate per 100,000	7.9	CDC WONDER (2018-2020)
Opioid emergency department visits	101	ESSENCE (2021)
Naloxone (Narcan) distributed per year, 4mg and 8mg doses	575	YCPH (2023)
YCCO member emergency department use for behavioral health, visits per 1,000 members	15	YCCO (2022)
Citations issued for motorists driving under the influence of intoxicants	59	OSP (2022)

GOALS AND STRATEGIES

The following goals and strategies were developed by the Collaborative and aim to impact the indicators listed above.

Goal 1: Expand mobile multidisciplinary crisis services.
Strategy 1: Develop 911 dispatch triage process for behavioral health calls.
Strategy 2: Increase case management follow up after initial incident response.
Strategy 3: Increase capacity to include overdose response.

FOCUS AREA: MENTAL HEALTH AND SUBSTANCE USE

Goal 2: Expand wraparound services to high utilizers of the emergency department for behavioral health needs.
Strategy 1: Engage and/or support traditional health workers and community-based organizations to provide navigation and resources
Strategy 2: Increase Traditional Health Worker (THW) capacity

Goal 3: Reduce stigma and increase awareness of support tools and resources for mental health and substance use.
Strategy 1: Support behavioral health education initiatives.
Strategy 2: Ensure behavioral health education initiatives are culturally responsive and available in Spanish.

Goal 4: Decrease deaths by suicide.
Strategy 1: Develop and implement suicide fatality review board.
Strategy 2: Expand education and prevention programs for general public.
Strategy 3: Offer targeted prevention to high-risk groups.
Strategy 4: Expand upstream education and prevention for youth.

Goal 5: Decrease DUIIs in Yamhill County.
Strategy 1: Partner with other organizations for education and prevention.
Strategy 2: Develop community messaging campaign.

FOCUS AREA: TRANSPORTATION

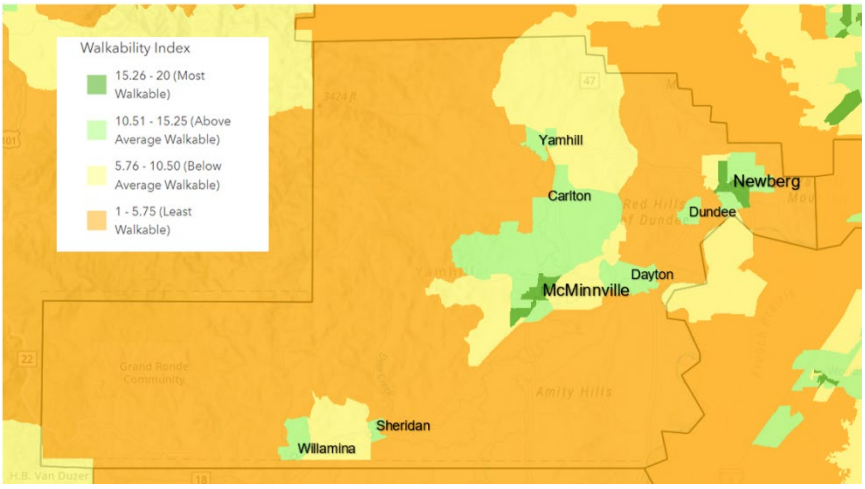
Overview

Access to safe, reliable transportation is not only necessary for accessing health services such as attending regular medical or dental appointments, but proper transportation can also determine a person's ability to access non-medical social needs, such as trips to grocery stores, financial institutions, non-medical community services, and parks and recreational areas. Stakeholders discussed there is a need for improved transportation between towns within Yamhill County, as well as out of the county to larger cities like Salem and Portland. Increased access to transportation supports many other community health initiatives, such as access to healthcare, food security, and access to parks and recreational areas. In the 2022 CHA Community Survey, 14% of respondents said that they had to go without transportation in the last year because they could not afford it.

Reliable transportation not only refers to the access of motorized vehicles and public transportation but also to non-motorized options such as bike lanes, safe sidewalks, trails, and other infrastructure that supports physical activity. Walkable, bikeable, transit-oriented communities are associated with healthier populations, as people in these populations are typically more physically active, have less weight gain, have lower rates of traffic injuries, and are less exposed to air pollution.[33] Support for walking and biking paths and public transit expansions could improve people's transportation options and co-locating services would reduce transportation barriers.

Figure 16 depicts the Walkability Index throughout Yamhill County and is based on 2019 census block groups.[34] The most walkable areas, designated as dark green, include the towns of McMinnville and Newberg. People in more rural areas of the county are less likely to be able to get to the places they need without a vehicle, nor easily access safe places to move their bodies for exercise or recreation.

Figure 16. Walkability Index, Yamhill County, 2021



Source: Environmental Protection Agency Office of Community Revitalization/Smart Growth Program, 2021

[33] https://www.rwjf.org/en/insights/our-research/2012/10/how-does-transportation-impact-health-.html

[34] National Walkability Index, https://epa.maps.arcgis.com/home/item.html?id=f16f5e2f84884b93b380cfd4be9f0bba

FOCUS AREA: TRANSPORTATION

HEALTH INDICATOR METRICS

Some of the indicators listed below are data from the CHA that illustrate part of the reason that transportation was chosen as a Focus Area. Additional indicators were selected based on the goals and strategies we developed. Identifying indicators at the beginning of the CHIP cycle helps us to measure and track our progress over time in order to meet our goals.

Indicator	Current State	Source (Year)
WellRide grievances filed	148	YCCO (2022)
Dial-a-ride ridership data	To be determined	YCTA
Ridership on Yamhill County Transit overall	To be determined	YCTA
Number of drivers contracted by Yamhill County Transit	To be determined	YCTA

GOALS AND STRATEGIES

The following goals and strategies were developed by the Collaborative and aim to impact the indicators listed above.

Goal 1: Increase the impact of on-demand transportation services.
Strategy 1: Increase promotion, education, and awareness of these services among target populations.
Strategy 2: Continue to monitor barriers to accessing Well-Ride.

Goal 2: Increase local public transportation routes and schedules.
Strategy 1: Assess feasibility of expanding transit services and recommend changes based on assessment.
Strategy 2: Support inclusive and equitable transportation policies.

FOCUS AREA: TRANSPORTATION

Goal 3: Increase utilization of transportation resources and options.
Strategy 1: Increase multilingual and multimodal communication promoting available transportation resources.
Strategy 2: Increase adoption of non-motorized transportation options.

Acknowledgements

The below organizations offered support, answered our questions, hosted or supported listening sessions, participated in stakeholder interviews, and/or provided feedback in the many iterations of this plan. They will continue to receive updates on CHIP progress and will be invited to provide feedback in the process. We are grateful for their input, expertise, time, and contributions to this work, which is always ongoing.

Partners Engaged

AGENCY	CATEGORY
Remnant Initiatives	Community based orgs
Yamhill Community Action Partnership	Community based orgs
Yamhill County Gospel Rescue Mission	Community based orgs
Service Integration Teams	Community councils
Parent Leadership Council	Community councils
Quality and Clinical Advisory Panel	Community councils
Yamhill Community Care Board of Directors	Community councils
Early Learning Council	Community councils
Yamhill Oral Health Coalition	Community councils
Yamhill County Commissioners	County councils
Yamhill County Board of Health	County councils
Yamhill County Developmental Disabilities Services	County services
Yamhill County Corrections	County services
Housing Authority of Yamhill County	County services
Unidos Bridging Community	Culturally specific agencies
Centro	Culturally specific agencies
Willamette Education Service District	Education
Willamina School District	Education
Gay Straight Alliance Newberg	Education
Virginia Garcia Memorial Health Center	Healthcare
George Fox University	Higher education
Linfield University	Higher education
Newberg City Council	Local government
Northwest Senior and Disability Services	Social services
Lutheran Community Services NW	Social services
Better Outcomes Through Bridges	Social services

Provoking Hope	Traditional health work
Promotores	Traditional health work
Yamhill Valley Community Doulas	Traditional health work

The agencies listed below are members of local advisory, governing, and government councils that reviewed, informed, and improved the CHA and CHIP's development and finalization. These councils include the Yamhill County Board of Health, Yamhill Community Care Board of Directors, Providence Service Area Advisory Council, Yamhill County Commissioners, Parent Leadership Council, Early Learning Council, Quality and Clinical Advisory Panel, and Oral Health Coalition.

Advisory and Governance Council Agency Representation

AGENCY	CATEGORY
Project ABLE	Traditional Health Worker agency
Oregon Health Plan members	Community at large
Parents	Community at large
Capitol Dental	Dental health
Physician's Medical Center	Healthcare
A Family Healing Center	Healthcare
Willamette Valley Pediatrics and Adolescent Medicine	Healthcare
Providence Newberg Medical Group	Healthcare
Virginia Garcia Memorial Health Center	Healthcare (FQHC)
West Hills Healthcare Clinic	Healthcare
Willamette Valley Medical Center	Hospital
Yamhill County Health and Human Services	Behavioral Health
Lutheran Community Services NW	Behavioral Health
Life Counseling	Behavioral Health
Miller Chiropractic Clinic	Specialty/CAM
George Fox University	Higher education
Linfield University	Higher education
Northwest Senior and Disability Services	Aging and disability services
Yamhill County Commissioners	County government
Oregon Child Development Coalition	Social services
Childcare Resource and Referral	Early childhood
Willamette Education Service District	Early childhood
Confederated Tribes of Grand Ronde Head Start	Education/Tribe

Amity School District	Education
Dayton School District	Education
McMinnville School District	Education
Newberg School District	Education
Sheridan School District	Education
Yamhill Carlton School District	Education
Willamina School District	Education
DHS/Child Welfare	County services
DHS/Self Sufficiency	County services
Housing Authority of Yamhill County	County services
Encompass Yamhill Valley	Community based organizations
Kiwanis	Community based organizations
Oregon Family Advocacy Council	Community-based organization
Unidos Bridging Community	Culturally-specific agency

Next Steps

The CHIP Collaborative has identified seven Advisory Groups to serve as subject matter expert guides in the implementation of this work. Each group is unique to the Focus Area's specifications. In some cases, a Focus Area needs multiple groups to offer guidance, as in the case of Mental Health and Substance Use. Multiple workgroups from within Health and Human Services will provide regular feedback on different parts of the plan. The workgroups for all seven Focus Areas are:

Focus Area	Advisory Group
Housing	Yamhill County Housing Leaders Group
Mental Health and Substance Use	Alcohol and Drug Policy Commission, Mental Health and Developmental Disability Advisory Council
Infants and Youth	Family Wellbeing Council
Transportation	Yamhill County Transit Area Advisory Board
Access to Healthcare	Yamhill Quality and Clinical Advisory Panel
Emergency Preparedness	Emergency Management Committee; Equity Advisory Workgroup
Food and Nutrition	Nutrition Oregon Campaign

YCCO, YCPH, and PNMC will continue meeting regularly to track progress within the plan and ensure alignment of resources and information. We will further refine our action steps for each strategy, developing a clear and detailed workplan to move this work forward. We will also develop a reporting and revision system, allowing for real-time updates to be made to the plan and provide easy reference to progress markers. Using this tracking system, the Collaborative will be able to share data back with the community, validating alignment with the community goals and addressing real need. This process will also allow us to update or remove any indicators that are no longer relevant.

Finally, the Collaborative is committed to gathering regular, meaningful community feedback so that members of the community understand how their information is being used (and not used) to evaluate and impact health outcomes. The Collaborative will use a shared platform to provide regular updates and produce reports. A formal annual report will be created and submitted to the Oregon Health Authority and posted online. Staff members will continue to hold listening sessions, create surveys, and connect with community groups to understand the changing local needs and budding initiatives.

Getting Involved

Want to get involved? We welcome feedback, participation in advisory or planning councils, and questions!

Yamhill Community Care
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Yamhill County Public Health
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